SB 8-75-S6

DEPARTMENT OF THE ARMY SUPPLY BULLETIN

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REPORTING ERRORS AND RECOMMENDING IMPROVEMENTS

You can improve this publication. If you find any mistakes, or you know a way to improve it, please let us know. Mail your letter or DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to the U. S. Army Medical Materiel Agency, ATTN: MCMR-MMI/IMIT, Fort Detrick, MD 21702-5001.

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Special Notice

This Supply Bulletin is Dedicated Entirely To The Dissemination of
Significant Changes and Special Emphasis Information
Contained In
The Draft AR 40-61, *Medical Logistics Policies*

Report Documentation Page

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OVERVIEW

The U.S. Army Medical Command (MEDCOM), is the Army Medical Department (AMEDD) focal point for establishing medical logistics policies, procedures, and programs for managing medical materiel and for logistics support at medical centers (MEDCENs), and medical department activities (MEDDACs), installation medical supply activities, and other medical units. The MEDCOM has drafted a major revision to AR 40-61, *Medical Logistics Policies,* for the proponent, The Surgeon General.

This edition of the SB 8-75-S6 is a **"one-time"** synopsis of the draft AR 40-61 that is currently undergoing final staffing.

ACKNOWLEDGEMENT

The MEDCOM extends appreciation to the U.S. Army Publication Agency for their permission to develop this publication. This supply bulletin permits the most significant information on medical logistics policy changes to be reviewed by personnel while final regulation staffing is being conducted.

Additionally, MEDCOM recognizes the efforts of numerous subject matter experts and points of contact to distill the significant changes and areas that require special emphasis within the draft AR 40-61 for inclusion in this publication. Making this information immediately available assists activities in recognizing those areas that are undergoing change due to the transformation in medical logistics business practices.

SECTION I. INTRODUCTION TO SB 8-75-S6, 2002

a. This SB 8-75-S6 highlights the significant changes within selected chapters of AR 40-61. These selected chapters appear as appendices within this publication. Also included are sections of these selected chapters that deserve special emphasis, due to the significant changes in the way the AMEDD conducts logistics business. A glossary is not included in this publication.

b. While this publication reflects portions of the most current draft of AR 40-61, it is emphasized that the entire regulation is currently undergoing final staffing and further changes may be incorporated as a result of this staffing. This publication is reproducible as a supplement to the current AR 40-61.

c. All MEDCOM organizations/activities are accountable for areas covered in this publication that are also contained in current Operation Management Bulletins or other MEDCOM policy directives. These areas will be assessed during command compliance reviews, such as the Command Logistics Review Program administered by MEDCOM.

d. The draft AR 40-61 may be viewed in its entirety on http://www.fedlogspt.com. To access the regulation from this site requires users to register on the website. To register simply go to the website and click on "Sign Up For Membership" and complete the user registration information. Ensure that you enter the correct electronic mail address. The website manager will review your user profile and respond with an electronic-mail message when approved. The approval review will be performed within 24 hours.

e. Once website access is obtained, follow these instructions:

- Log onto the website.
- Click on the "Army" button located in the top bar.
- Select the "E-Programs" button on the Army homepage navigator located on the left sidebar.
- Select AR 40-61 from the drop-down menu followed by the desired viewing area/chapter. The "print" button can be used if a hard copy of the selected area is desired.

APPENDIX A. DRAFT AR 40-61
CHAPTER 2. Medical Logistics Systems

I. SIGNIFICANT CHANGES

The Army Medical Department (AMEDD) added this new chapter to identify authorized automated information systems (AIS) for medical logistics operations and to describe policy governing their use.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 2 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

2-1. Medical Logistics Automated Information System (AIS) Guidance

This paragraph applies to medical logistics automated information systems (AIS) at automated medical logistics operations, medical fixed facilities, division, and corps level units (Echelon II-V). This paragraph is in accordance with AR 25-1.

a. Medical logistics AISs will support the following core business functions:
(1) Acquisition, accountability, and distribution of materiel and equipment.
(2) Use, maintenance, and repair of facilities supporting the AMEDD medical mission.

b. Army medical fixed facilities and units conducting medical logistics operations will use existing DoD/Army standard medical logistics AISs. Units will migrate to future DoD/Army AISs when they are implemented.

c. Medical fixed facilities and units conducting medical logistics operations will not use locally developed or procured non-standard medical logistics systems when either a DoD or Standard Army Management Information System (STAMIS) is available.

2-2. Medical Logistics AIS Definitions And Exception Policy

a. The following systems are authorized as standard DoD and Army Logistics Management AISs:
(1) Theater Army Medical Management Information System (TAMMIS).
(a) Medical Supply (MEDSUP).
(b) Medical Maintenance (MEDMAINT).
(c) Medical Assemblage Management (MEDASM).
(2) Army Medical Department Property Accounting System (AMEDDPAS).
(3) Defense Medical Logistics Standard Support (DMLSS).
(4) Purchase Request Web (PRweb).
(5) Defense Blood Bank System (DBBS).
(6) Spectacle Request Transmission System (SRTS).
(7) Global Combat Support System-Army (GCSS-A) Maintenance (MNT).
(8) GCSS-A Supply and Property (SPR).

b. When standard systems do not provide the functionality to support a required medical logistics business practice, non-standard AISs are authorized only after approval through the AMEDD DOL/ACSLOG. Units shall submit a request for waiver through their respective Regional Medical Commander (RMC) to Commander, USAMEDCOM, ATTN: MCLO-LS, 2050 Worth Road, Ste 8, Fort Sam Houston, TX 78234-6008.

c. Army medical activities and units operating a manual medical accounting system will follow this regulation and procedures in AR 710-2, and DA PAM 710-2-2.

d. Army medical fixed facilities are authorized to use commercial automated medication and supply management systems, known as Point of Use (POU). Command approval is required to purchase or lease POU systems. Requests to purchase or lease POU systems will be submitted through the respective Regional Medical Command (RMC) to:

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth Road
Fort Sam Houston TX 78234-6000

Requesting activities will submit justification that includes projected economic and clinical benefits.

(1) Activities with POU systems will follow prescribed security measures and system requirements for medication management outlined in AR 190-51. Activities with POU systems will maintain written policies and procedures for security, accountability, and emergency situations. Policies and procedures are intended to supplement existing MEDCOM, Army and DoD regulations and directives.

(2) The AMEDD has developed standard interfaces for POU with TAMMIS, DMLSS, and Composite Health Care System (CHCS). Activities implementing POU will ensure that these interfaces are implemented. Activities are not authorized to use stand-alone POU systems for supply or medication management. Installation of interfaces will be coordinated through the

Commander, USAMEDCOM
ATTN: MCLO-LS
2050 Worth Road, Ste. 8
Fort Sam Houston TX 78234-6008

(3) Army medical activities with automatic identification technology (AIT) equipment, that includes Radio Frequency (RF) devices, such as base radio units, repeaters, hand held terminals, scanners, and printers will utilize and maintain the equipment. Trouble calls for AIT equipment in support of DMLSS applications will be submitted to the DMLSS Customer Support Office, IAW established procedures.

(4) Trouble calls for AIT equipment in support of TAMMIS and AMEDDPAS will be submitted to the United States Army Medical Information Systems and Services Agency (USAMISSA), Customer Support Office, in accordance with established procedures.

APPENDIX B. DRAFT AR 40-61
CHAPTER 3. Army Medical Materiel Management

I. SIGNIFICANT CHANGES

- Describes the medical supply support activity (SSA) operation and prescribes what activities will be funded with the Defense Wide Working Capital Fund (DWWCF).

- Defines specific acquisition methodologies and provides guidance to accomplish cost-effective and efficient supply support.

- Prescribes the use of medical logistics AIS in providing supply support.

- Defines materiel standardization and provides guidance for implementing materiel standardization in support of the DoD Regional programs. Parameters are set that define those items excluded from the standardization efforts, and the objectives for standardization within the RMC and Health Care Activity (HCA) are established.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 3 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

3-3. Medical SSA

The SSAs for medical materiel provide direct, general, and/or installation support to units and activities within a designated command or area. The unit's or activity's MTOE, TDA, or MACOM directive will state the mission for providing this support. Establishing new SSA accounts that requires DWWCF or DHP funding must be coordinated with the MEDCOM ACSLOG.

a. The SSAs for medical materiel include—
(1) Installation Medical Supply Activity (IMSA).
(2) Medical Logistics Battalion (MEDLOG Bn). In peacetime, MEDLOG Bns may perform the full functions of a SSA, may have a training mission, or may have an area supply mission. Upon mobilization and/or deployment, the MEDLOG Bn will normally perform all functions of a SSA.
(3) U.S. Army Medical Materiel Center Europe (USAMMCE).

b. The SSA will—
(1) Operate a stock record account per AR 710-2 and this regulation.
(2) Operate with a standard MEDLOG automated system, following the system's prescribed procedures.
(3) Requisition/order materiel directly from Defense Logistics Agency (DLA), Veterans Affairs (VA), supporting contracting office, or from another SSA/distribution center.
(4) Conduct prescribed FIA and financial management of the:
(a) Operation and Maintenance, Army (OMA) fund in TOE units.
(b) Operation and Maintenance, Defense (OMD) fund in designated TDA hospitals within the AMEDD.
(c) Defense Wide Working Capital Fund (DWWCF) in selected AMEDD activities.

c. Under the Army's Single Stock Fund initiative the retail stock fund for Class VIII (Medical) was excluded from the Army Working Capital Fund. SSAs for the AMEDD are now funded depending on their mobilization and deployment support mission. If an activity is designated as a FORSCOM Power Projection Platform (or supporting a FORSCOM designated

Power Projection/Power Sustainment Platform), a planned Reachback site or an OCONUS distribution center, they will utilize the DWWCF through Defense Logistics Agency's (DLA) DSCP. Activities not meeting the above criteria will use Defense Health Program (DHP) funds to support their SSA.

d. Other supply operations for medical materiel maintain informal stock control records in support of a direct support or area supply mission.

3-5. Acquisition Methodologies And Guidance

a. Acquisition methodologies are designed to provide the most cost effective and efficient support within the regions, while capitalizing on better business practices. Automated order entry and a paperless acquisition environment are integral to achieving better materiel support. The goal is to migrate to greater use of electronic commerce alternatives and decrease reliance on manual labor-intensive procurements. Regional Logistics Chiefs, HCA Logistics Division Chiefs, and Accountable Officers will ensure the procurement method utilized provides the best corporate value and allows a corporate view of procurements for standardization of materiel and services. The acquisition methodology utilized to purchase materiel and services may vary by item. At all times, the method used should be planned and selected to provide the product or service when needed at the best price. Additionally, the method utilized must enhance the materiel and service acquisition strategies within MEDCOM and the RMC.

b. The following are the acquisition method strategies listed in the established priorities for acquisition:

(1) DSCP Prime Vendor Program (Prime Vendor distributed items which include: Distribution and Pricing Agreement (DAPA) items; Federal Supply Schedule items; Prime Vendor non-usage items; Prime Vendor committed volume/regional incentive agreements (RIA); Prime Vendor program e-commerce and other e-tool sources).

(2) DSCP Electronic Catalog (ECAT)

(3) PRweb/Local Purchase Instruments (Decentralized Blanket Purchase Agreements (DBPA), Blanket Purchase Agreements (BPA), Indefinite Delivery Indefinite Quantity contracts (IDIQ)

(4) Other e-commerce and dot-coms (e.g., Department of Veterans Affairs (VA) ordering sites)

(5) DSCP Depot (Centrally managed and Military/Service unique items)

(6) Government Credit Card

3-6. Expanded Acquisition Guidance

a. Commercial distributor (Prime Vendor) is the primary acquisition method for materiel purchasing. The use of the DSCP Prime Vendor program is mandatory for the acquisition of products that are available through it. The MEDCOM will establish management goals and objectives to provide accountability for this mandatory business process. These goals and objectives will be published in the DA PAM 40-61 and in other command publications or media.

b. The DSCP ECAT program can be used for laboratory, optical, dental, and medical equipment product lines. AMEDD organizations will utilize ECAT as a mandatory source of supply for those items that are available under the program. Using ECAT minimizes administrative overhead through streamlined financial processes available through the Military Standard Billing System (MILSBILLS).

c. The use of purchase orders will be minimized for repetitive purchases. If a purchase order is required (e.g., PV or ECAT are unavailable), DBPAs, BPAs or IDIQ contracts

will be established with vendors to obtain the best pricing and reduce investment in inventory. A just-in-time (JIT) philosophy will be used rather than automatic deliveries that could contribute to unnecessary and expensive inventory stockpiles.

(1) Within the MEDCOM, paperless contracting using PRweb is the method for generating and processing local purchase requests for supply purchases above the Government Credit Card/International Merchant Purchasing Authorization Card (IMPAC) authorizations. PRweb is used to gain process efficiency and establish a closed-loop process from acquisition to contracting to finance, and minimize Prompt Payment Act penalties.

(2) The DBPAs will be established through MEDCOM, DSCP or the VA with suppliers of medical materiel, equipment, and limited repair parts not otherwise available through a prime vendor or other requirements contract.

d. The use of other electronic commerce purchasing sites, such as other prime vendor sites or the VA sites, is authorized. Specifically, the VA is an authorized source of medical materiel. The Office of Acquisition and Materiel Management's National Acquisition Center (NAC) is the largest combined contracting activity within the VA. The NAC is responsible for supporting the health care requirements for VA as well as the needs of other Government agencies. The NAC is solicits, awards and administers VA's Federal Supply Schedule and National Contract Programs including the acquisition and direct delivery of pharmaceuticals, medical/surgical/dental supplies, high technology medical equipment and just-in-time distribution programs (also known as Prime Vendor Distribution Programs). The NAC is comprised of two services: Federal Supply Schedule Service and National Contract Service. These Services oversee specific programs as stated for such commodities as medical, dental, and surgical supplies and equipment, pharmaceuticals, chemicals, medical equipment, and laboratory items. Local purchases of medical materiel, equipment items, and other specialty items are authorized using the Federal Supply Schedule Service.

e. DSCP Depot procurements will only be utilized for centrally managed, Military/ Service-unique items.

f. Reduce the number and use of decentralized Government Credit Cards. The credit card can be used as a method of payment for other purchasing methods, e.g., BPAs or web-based ordering. However, the credit card is the least preferred method for purchasing recurring demand materiel or services. The MEDCOM activities will use only MEDCOM contracting office-issued credit cards. The MEDCOM activities will not apply for, accept, or use credit cards issued by other Army major commands. Credit card decentralization and ease of use produces procurement situations that are often not planned or managed, may circumvent Prime Vendor or other more cost-effective acquisition methods and ultimately result in paying higher or commercial prices for materiel and services. Credit cards can remain decentralized for sites with peculiar, unique or specialized requirements (e.g., veterinary and dental activities, pharmacies). Credit card purchases will be captured in Logistics AIS databases (TAMMIS/DMLSS) for retrospective review by the Accountable Officer to capture demands for standardization, and to ensure that more cost effective procurement methods are considered in future procurements.

3-7. Logistics AIS Policy

Maximize use of logistics AISs, i.e., TAMMIS/DMLSS, to maintain centralized visibility of all materiel and services procurements. Where a DoD/Army AIS is available, it will be used regardless of who is managing the commodity, e.g., pharmacy. All transactions will be loaded into the logistics AIS database so that accountable officers can functionally review and effect necessary changes to the procurement processes utilized. Medical/surgical, maintenance, and office product procurement processes will be centralized to provide oversight and management through the most preferred acquisition method/strategy and to capture usage for

standardization efforts. Regional Logistics Chiefs are the authority in deciding the extent to centralize acquisition processes within the HCA Logistics Divisions.

3-16. Materiel Standardization Definition

Materiel standardization is an integral part of the decision-making processes and functions associated with medical surgical supply items and cost analysis for medical equipment and services purchases. Materiel standardization is the cornerstone initiative of regional logistics programs, and presents significant opportunities for direct and indirect financial savings. Materiel standardization can support clinical efforts for utilization management and development of outcome-based pathways and protocols. Successful materiel standardization methods require a clinically led process that selects and procures the most appropriate products, based on cost and clinical acceptance, for use throughout a DoD healthcare region or RMC. Standardization ranges from the selection of individual items to broad product groups.

3-17. Implementing Materiel Standardization

a. Materiel standardization consists of two tiers: product decisions, which include items with large volume usage or increased cost, and reduction in the variety and number of different items purchased. All RMCs and HCAs will actively participate in their Tricare Region's standardization efforts under the regional logistics support program. Both RMCs and HCAs must establish processes to support and document participation in Tricare Regional standardization initiatives. Each RMC will support regional standardization and other logistics initiatives, by serving as a focal point for coordination among regional customers and HCAs, supporting acquisition agencies, and private-sector vendors.

b. The RMCs and HCAs will work with and support their Tri-Service Regional Business Office (TRBO), the operation and management arm of the Tricare Region's standardization program, and the Tricare Region's Logistics Chief to:

(1) Define target products and product groups. This is the first step with an analysis of where regional supply dollars are spent. This step identifies the primary users of the major product groups and assesses the degree of clinician preference for each product group.

(2) Select and prioritize products for standardization. The standardization of broad product groups targets those products that account for high-volume and high-dollar expenditures. This allows the standardization of many individual product lines with a single effort.

(3) Develop and select acquisition strategy. Specific acquisition strategies vary by product groups. High-demand items that fall into major product groups should be negotiated committed-volume regional incentive agreements through the prime vendor. Items that are low-demand, items with high unit cost, and items with highly specialized clinical applications should be purchased through web-based ordering systems such as DSCP's electronic catalog (ECAT) program.

(a) Items that have higher quality requirements or a lower cost than current stocked items are strong candidates for standardization review.

(b) Item groups with common functions will be identified for periodic review. Examples of item groups are catheters, surgical packs, needles and syringes, surgical gloves, and plastics.

(4) Conduct evaluation. A clinically led team comprised of clinicians from appropriate specialties and from each military service for regional evaluations, should evaluate product groups. This Clinical Product Team (CPT) will conduct an impartial, clinical evaluation of proposed products from the users' perspective. They will establish selection criteria and evaluation strategy for the product groups under consideration. Recommendations and findings will be reported back through the Tricare Region. The CPT process will be facilitated and documented using the Federal logistics portal standardization tool.

(5) Review the critical item list to ensure critical items are considered for standardization.

c. Activity level standardization processes will be established within the RMCs and HCAs. Internal processes will be developed and documented that support Tricare Region standardization efforts and decisions. Processes will include a review mechanism that indicates how the activity is in compliance with the standardization decisions. Each RMC and HCA will support data calls for the Tricare Region standardization process. Additionally, each will support the Tri-Service Product Review Board. This board will be chaired by the Tricare Lead Agent's medical director/senior clinical leader and have clinical and logistics representation from each Service. Individual RMCs or HCAs may establish a local standardization committee to ensure an organized and proactive approach to materiel standardization within the RMC and HCA and to support the Tricare Region's standardization efforts. If a local standardization committee is established, products and/or product categories approved through that process will complement and not compromise the Tricare Regions annual priority standardization efforts.

d. Each RMC will establish, implement, and monitor the progress of initiatives to meet the goals and objectives of the standardization program. They will establish procedures to identify and document resources, costs, and savings to this program. Standardization efforts throughout the Tricare Region focus on:

(1) Reducing variation in items purchased throughout the region.

(2) Facilitating clinical participation and acceptance of standardization efforts.

(3) Complying with the mandatory participation in Tricare regional initiatives and negotiated incentive agreements/RIA.

(4) Decreasing inventory while increasing product velocity.

(5) Creating supply cost savings or avoidances.

e. The RMC commander will ensure all HCAs within the region are in compliance with the Tricare regional standardization initiatives. The RMC commander will establish mechanisms to measure compliance for materiel and equipment standardization, which is regionally approved by the Lead Agent. The exception is dental and veterinary unique items or issues that are approved by ADL, VETCOM, or DENCOM.

f. Any item or product standardized at the local, HCA level, that is not provided under the DSCP committed volume contracts initiative (Prime Vendor, FSS), must receive exception and approval through the RMC and Tricare Regional Logistics Chiefs.

3-18. Materiel Standardization Parameters

All medical materiel used by more than one functional area within the HCA is subject to standardization policies, except for, the following:

a. Drugs (AR 40-3)
b. Books, periodicals, and journals
c. Medical gases
d. Repair parts
e. Hearing aids, prosthetic devices, and implants
f. Materiel for supported medical research and development
g. Food supplements

3-19. Materiel Standardization Efforts

The objectives of materiel standardization throughout the RMCs and at the HCA/activity level are:

a. To reduce the numbers of different medical products and equipment items procured by the MHS.

b. To ensure that the military is buying the right products and improving acquisition strategies to achieve the lowest cost.

c. Work with the Regional Logistics Chief, Logistics Division Chief and acquisition agencies to produce consumption data on items under consideration for standardization to negotiate committed volume discounts from the manufacturers.

d. Enforce the use of standardized equipment and supplies throughout the RMC and the HCA.

e. Conclude and implement standardization decisions, which achieve supply cost savings and/or cost avoidances. Each region must ensure an integrated reporting process exists to review and submit final recommendations within the Tricare Region standardization process. Product decision implementation includes the execution of the purchasing acquisition methods such as RIAs and DAPAs. This decision implementation should be coordinated with the prime vendor. The DAPA and RIA use is mandatory. The implementation and introduction of the standardized product involves the phase-in inventory, any product trade-in, credit, or equipment exchange. Phasing may also involve marketing and education to promote use of the new product with the clinical staff.

f. Monitor compliance. This will ensure that the products are introduced and used as agreed with the selected vendor. This will also ensure that expected benefits from the purchasing agreements are realized.

APPENDIX C. DRAFT AR 40-61
CHAPTER 4. Quality Control, Shelf Life, and Medical Materiel Complaints

I. SIGNIFICANT CHANGES

All Quality Control-related information has been centralized and incorporated into one chapter (Chapter 4) in the revised edition of AR 40-61. Chapter 4 is comprised of five sections:

I. Quality Control of Medical Materiel
II. Storage and Shelf-Life of Medical Materiel
III. Surveillance, Recalls, and Suspension
IV. Disposal and Destruction of Medical Materiel
V. Medical Materiel Complaints

- Procedural information delineating specific processes on the above topics may now be found in the newly revised DA PAM 40-61.

- QC messages (MMQC, SLEP, AND MMI) are available on the USAMMA's website at www.armymedicine.army.mil/usamma. Select **DoD MMQC messages** on the side bar to access QC messages ranging from newly released to three years past.

- DoD-FDA Shelf Life Extension Program (DoD-FDA SLEP) information is available on the USAMMA'S website including background information on the program, list of items currently approved for testing, on-line nomination capabilities, and more.

- Filing of the SF 380 (Medical Materiel Complaint) is now possible electronically on the USAMMA's website, select **DoD SF 380** on the sidebar. Comprehensive instructions and additional information is also available.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 4 – Selected paragraph is shown.)*

4-7. Management Of Shelf Life Items

d. Military-Unique (MU) and Medical NBC Materiel (MNBCDM) mandatory extension actions. The USAMMA publishes a list of items currently approved for testing in the DoD-SLEP on its website at www.armymedicine.army.mil/usamma, DoD/FDA SLEP.

e. Medical Chemical Defense Materiel (MCDM). MCDM (to include autoinjectors) will not be relabeled at the unit level. Materiel is placed in the shelf-life-extension program and only relabeled as required. Relabeling will only be accomplished by the manufacturer.

APPENDIX D. DRAFT AR 40-61
CHAPTER 5. Medical Equipment Management

I. SIGNIFICANT CHANGES

- Establishes responsibilities for the roles of Chief Property Management/Equipment Management, Property Book Officer, and Hand Receipt Holder/Custodian.

- Procedural guidance removed from the chapter and placed in a DA Pamphlet. The result is a condensed version of the information previously in the Army Regulation.

- Establishes policy on privately owned medical equipment brought to the HCS by a staff member or patient and used for treatment purposes.

- Eliminates most of the MEDCASE procedures contained in the current AR 40-61. MEDCASE procedures now reside in SB 8-75-MEDCASE.

- Expands on the policy in AR 710-2 for accountability of equipment rented, leased or borrowed.

- Provides policy for the loan of TDA equipment to MTOE activities.

- Includes a total rewrite of the procedures for acquiring medical and non-medical equipment in MTOE units.

- Gives deployed medical MTOE units guidance on acquiring medical equipment not authorized by their current MTOE, however, needed to perform their current contingency mission.

- Institutes the Patient Movements Items (PMI) program.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 5 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

5-3. Property Management Responsibilities

The position of Chief, Property Management has been with us for some time now. Never have the actual duties and responsibilities of this position been formally defined. This revision of AR 40-61 clarifies those duties and responsibilities. Along with the duties of the Chief, Property Management, the duties of the Property Book Officer are further defined from those in AR 710-2. Also, the duties and responsibilities of the Hand Receipt Holder/Custodian are described in detail. The text of that paragraph follows:

a. Chief, Property Management. The Chief, Property Management is responsible for:
(1) Providing direction, leadership, and general supervision in the implementation and maintenance of the property management program throughout the organization.
(2) Establishing and maintaining the organization regulations and procedures satisfying Department of Defense and Department of Army guidance and the various laws.

(3) Defining hand receipt/custodial areas within the organization.

(4) Establishing and training the organization's property management team comprised of the Property Book Officer, Hand Receipt/Custodial Managers, and Hand Receipt Holders/Custodians.

(5) Developing and implementing inventory schedules for the organization, monitoring inventory progress, and reconciling property records.

(6) Ensuring that required reports are provided.

(7) Implementing procedures for the repair and rehabilitation of property within the organization.

(8) Ensuring excess property is promptly inspected and reported for disposition. Final disposition instructions are followed when received.

(9) Ensuring that lost, stolen or damaged property is investigated in accordance with AR 735-5.

b. Property Book Officer. The Property Book Officer is responsible for:

(1) Ensuring the effective administration and maintenance of the system of control and accountability for property belonging to their organization.

(2) Ensuring that Hand receipt Holders/Custodians have current records for assigned accountable property.

(3) Ensuring that physical inventories are taken, records are reconciled and discrepancies are investigated and resolved.

(4) Ensuring that Reports of Survey for lost, damaged or destroyed property are promptly processed in the property accounting system. Overall Report of Survey processing times are a function of the Report of Survey Appointing Authority.

(5) Ensuring that property is fully utilized, safeguarded from misuse or theft, and that unneeded property is promptly reported for reutilization, redistribution or disposal.

(6) Coordinating with the Chief, Property Management criteria for replacing or upgrading over-age equipment.

(7) Ensuring that bar code labels are affixed on accountable property.

(8) Ensuring that additions, transfers and deletions are entered into the property accounting records in a timely manner.

c. Hand Receipt Holder/Custodian. The Hand Receipt Holder/Custodian is responsible for the immediate physical custody of all property under their control. The appointment as a Hand Receipt Holder/Custodian may or may not correspond to the individual's official job title. The Hand Receipt Holder/Custodian is responsible for:

(1) Maintaining current hand receipt/custodial records for all accountable property within their assigned area.

(2) Initiating or processing, in accordance with local procedures, documents affecting the accountability or custody of property.

(3) Ensuring that property has proper maintenance and protection, and is used only for official purposes.

(4) Identifying and reporting to the Property Book Officer any property excess to the needs of the area.

(5) Promptly initiating Reports of Survey for lost, damaged, or destroyed property.

(6) Assisting with and/or conducting physical inventories and reconciling property records.

(7) Assisting with exit clearance procedures to ensure that all assigned property is accounted for and transferred to the new Hand Receipt Holder/Custodian.

5-6. Loan Of TDA Equipment To MTOE Organizations

This paragraph gives the HCA commanders authorization to loan equipment items to MTOE units under certain conditions. Approval of the RMC is required to initiate the loan. The HCA commanders may temporarily loan medical and nonmedical equipment items to MTOE units with the approval of the RMC. Equipment should only be loaned to satisfy urgent deployment requirements and/or those requirements needed to meet extended DA/Joint Chief of Staff directed exercises. Follow the guidance in AR 700-131 when loaning equipment.

5-12. Privately Owned Medical Equipment

The use of privately owned medical equipment in the HCA is a topic that comes up repeatedly, especially around the time for a JCAHO inspection. There is now a standard MEDCOM policy that all HCA can use or reference in the development of their own internal policy.

a. Privately owned medical equipment is any item that is brought to the HCA by a staff member or patient and used for treatment purposes. The Army does not authorize the use of privately owned equipment within HCAs. Use of this equipment places the HCA's JCAHO accreditation in jeopardy. Army Regulation 25-1 provides guidance on using privately owned automation equipment. Coordination with the PBO for accountability on all ADPE is mandatory.

b. The HCA commander will enforce this policy. Staff members or patients can submit requests for waivers through the HCA commander to Commander, USAMEDCOM, ATTN: MCLO, 2050 Worth Road, Suite 8, Fort Sam Houston, Texas 78234-6008.

c. The Comprehensive Accreditation Manual for Hospitals: The Official Handbook imposes extensive requirements for written documentation for all equipment used in the HCA, regardless of ownership. These requirements are key factors in the JCAHO accreditation decision process.

d. When health care is provided on a contractual basis, the contract must--
(1) Clearly identify all medical equipment used in the treatment facility.
(2) Determine the liability, security, accountability, and maintenance responsibilities.
(3) Specify the JCAHO compliance requirements

e. Patient-owned, non-medical comfort equipment (e.g., hair dryers, curling irons, electric razors, radios, etc.) falls under the purview of the HCA Safety Officer/Manager. The HCA Safety Officer/Manager will establish a policy for its' introduction and use within the MTF and, if allowed to be introduced, will inspect and document this and all other non-medical electrical equipment. Inspections must be conducted IAW NFPA 99 to maintain JCAHO accreditation.

5-23. Equipment Acquisition for Deployed Medical TOE Units

Medical MTO&E units are frequently assigned contingency missions (i.e. humanitarian aide, garrison medical treatment) far different from their basic wartime mission. Most of these units are not authorized the equipment to perform these missions. Incorporated in this regulation is authorization for MTO&E units to acquire equipment to support their contingency mission.

This section provides guidance to Medical Task Force Commanders and commanders of deployed medical units for acquiring medical equipment not authorized by their current MTO&E, however, needed to perform their current contingency mission. This guidance is

intended specifically for deployed United States Army medical units in support of contingency missions.

a. Operating guidance:

(1) The clinicians or care providers prepare a memorandum justifying the request for medical equipment. The memorandum should contain a detailed justification and impact on the health services mission if the equipment is not obtained. The Medical Task Force Commander serves as the initial review authority for item requirements.

(2) Requirements approved by the Medical Task Force Commander will be forwarded through staff channels to the Command Surgeon for final action. The Command Surgeon will either approve or disapprove the request and notify the requesting deployed Medical Task Force Commander. This regulation will be sited as approval authority.

b. The command surgeon will publish instructions for requesting approved medical equipment items. Task force funds will be used to fund purchases of medical equipment. The requesting unit must ensure an accurate "ship to" address and supplementary address, which includes the unit's DoDAAC, UIC, location of the unit, phone and fax number and email address. Priority of shipment must be addressed using the MILSTRIP Priority Designator System.

c. The memorandum, with the approval of the Command Surgeon, is authorization for the equipment. A copy will be retained in the unit's equipment authorization files. The property book will site this regulation as authority for the equipment. Equipment authorized for a Task Force Mission will be processed as excess upon completion of the mission.

APPENDIX E. DRAFT AR 40-61
CHAPTER 6. Medical Equipment Maintenance

I. SIGNIFICANT CHANGES

- Provides additional guidance and responsibilities for MTO&E Units.
- Provides greater definition of levels of maintenance support and support responsibilities.
- Authorizes the use of maintenance forms designed for/fielded with authorized maintenance management systems.
- Establishes the requirement for commanders to publish a maintenance directive assigning maintenance responsibilities for maintainers, operators, and supervisors at all levels.
- Deletes the requirement for use of the DD Form 2163 on defibrillators.
- Authorizes commanders to delegate, in writing, authority for the Chief, Logististics to approve waivers of expenditure limits for the repair of equipment falling below the MEDCASE threshold.
- Establishes the USAMMA as the responsible agency for the AMEDD TMDE program and provides the guidance for TMDE users/requestors.
- Requires the use of AMEDDPAS and/or DMLSS to manage repair parts.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 6 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

6-2. Maintenance Policy

a. Medical equipment maintenance is ultimately the responsibility of the medical activity commander. Each commander will provide for the maintenance of medical equipment issued to or under the responsibility of the activity to include the efficiency of programs established for this purpose.

b. MTO&E commanders will report the status of selected medical items of equipment IAW AR 220-1 and AR 700-138.

c. The medical equipment maintenance function is limited to maintenance activities tasked by TSG, Command Surgeons, and RMCs/MSCs to support the AMEDD mission.

(1) Medical maintenance activities organic to MEDCENs, MEDDACs, MEDLOG Bn, USACHPPM, AFIP, Regional Training Sites-Medical (RTS-MED), and the USAMMA maintenance divisions will publish their external maintenance support procedures for use by customers.

(2) The MEDLOG Bn will establish a support agreement with supported unit commanders. This agreement must define requirements of both the supported unit and the supporting activity for administration of a proactive medical materiel maintenance program.

(3) Each installation, except those where RTS-MED are located with other HCAs, will have only one TDA HCA assigned a medical equipment maintenance function. Resourcing of the maintenance can be either centrally funded when the USAMEDCOM budgets the TDA HCA or funded on a cost reimbursement basis. The Surgeon General is the approval authority for any exceptions.

d. The MACOMs possessing medical equipment maintenance capabilities will coordinate the maintenance resources. The MACOMs will establish formal agreements with primary emphasis directed toward the achievement of a high state of unit readiness and the maintenance of managerial and technical skills of their personnel.

e. TDA medical maintenance activities will accomplish their support mission to ensure that the supported activities comply with applicable standards pertaining to the maintenance of medical equipment promulgated under:

(1) Code of Federal Regulations (CFR) Chapters 21 and 29.
(2) Commission on Laboratory Accreditation.
(3) Comprehensive Accreditation Manual for Hospitals: The Official Handbook.
(4) National Fire Protection Association (NFPA) 99 and Life Safety Code 101.
(5) All other applicable Federal safety and health standards.

f. The Surgeon General (TSG) must approve the use of contract maintenance for unit, direct, and general support maintenance for materiel fielded under MTOE. Use of RTS-MED is authorized on a limited basis as government-owned contractor operated activities.

g. Scheduled periodic maintenance services take precedence over all but emergency repair requirements. The final judgment is that of the equipment maintenance manager.

h. Maintenance services will be performed at the lowest level of maintenance authorized with the capability and capacity to perform the service. The unit may overhaul equipment provided the capability exists, and the overhaul has been approved by the Command Surgeons or RMC/MSC.

i. The integrated logistics support plan will be adhered to throughout the life cycle of medical materiel to ensure adequate logistics support. (See AR 700-127.)

j. Medical equipment acquisition policies and procedures will be followed to minimize logistics support requirements. (See AR 40-60.)

k. Each item of medical equipment will be tested for serviceability and electrical safety prior to initial use and at least annually thereafter unless otherwise recommended by the original manufacturers' guidelines. The testing will be documented as prescribed by the appropriate major command (MACOM).

l. The MER will test medical equipment in storage, including APS and Operational Projects (OP) equipment per TB MED 1. MERs will manage medical equipment in MTOE units, although temporarily stored (for example, between field training exercises), as equipment in use for scheduled periodic services.

m. The management of maintenance functions, operations, and programs will be accomplished through DA or MHS standard systems.

(1) Technical Bulletin 38-750-2 prescribes procedures for the preparation and management of forms and records by units.
(2) The AMEDDPAS is the automated maintenance management system for TDA HCAs. The AMEDDPAS will be used until a replacement MHS AIS is fielded and becomes the automated maintenance management system for all TDA HCAs.
(3) In TDA HCAs, use the forms designed for and/or fielded with the MHS AIS in lieu of DA Forms 2407, etc.
(4) The TAMMIS MEDMAINT, SAMS1, or ULLS-G are the automated maintenance management systems for MTOE units. These systems will be used until a replacement MHS AIS is fielded and becomes the automated maintenance management system for all MTOE. The

ULLS-G will be fielded to units with an organizational maintenance mission and SAMS will be fielded to units or activities with a DS/GS. The Army STAMMIS systems will migrate to Global Combat Support System-Army (GCSS-A).

(5) The TCAM, SAMS1, or ULLS-G will be used by MTOE medical maintenance operations to manage repair parts.

n. The specific maintenance policies that apply to the ARNG follow—

(1) State maintenance officers must coordinate medical maintenance support.

(2) Medical maintenance requirements beyond unit capabilities may be supported from the following resources:

(a) Other ARNG medical maintenance resources in the State.

(b) The USAMEDCOM organizations with area support responsibility (on a reimbursable basis).

(c) The USAMMA maintenance divisions (on a reimbursable basis).

(3) The SB 8-75 series provides additional ARNG specific medical equipment maintenance guidance.

o. The MER will be used for medical maintenance duties. Do not assign MERs additional duties that may adversely affect the maintenance of medical equipment. Do not routinely use MERs for other than the maintenance of medical equipment. Do not assign the MERs additional duties if the Chief, Medical Maintenance has identified and documented that additional duties will impact on the following:

(1) The need for repair or inspection of medical equipment.

(2) The readiness of the unit.

(3) The cost of repair required to return the medical equipment to an operational status per manufacturers' requirements or Federal standards has increased.

p. Each activity commander with a medical equipment maintenance mission will publish a directive emphasizing the responsibilities of supervisors and equipment operators for the care and maintenance of medical equipment.

6-6. Calibration, Verification, And Certification Services (CVC)

a. Perform CVC services on medical equipment per Federal regulations, TB MED 750-1, manufacturers' literature, or other applicable standards.

b. Perform CVC services on organic medical equipment IAW the applicable MAC or other reference document (e.g., manufacturer's literature. TB MED 521, etc.).

c. Upon completion of CVC services, attach a DD Form 2163 (Medical Equipment Verification/Certification) (label)) to the item. Technical Bulletin 38-750-2 contains the instructions for completing DD Form 2163. Subsequent CVC services will be recorded on this label.

d. Only qualified personnel will perform maintenance and calibration services on medical equipment producing ionizing radiation. Services shall be conducted to verify that equipment meets performance requirements outlined in the applicable standard.

(1) The Federal requirement to provide CVC and repair services to components of medical equipment producing ionizing radiation originates in 21 CFR 1020, subchapter J. This regulation requires manufacturers of medical equipment producing ionizing radiation to meet specific performance criteria as described in 21 CFR 1021.31, subchapter J. The manufacturers will then provide the necessary written maintenance instructions and maintenance interval schedules that, in the manufacturers' opinion, will keep their equipment in compliance with all specific performance criteria.

(2) The MER will calibrate all medical equipment producing ionizing radiation used in HCAs (fixed or mobile) annually (plus or minus 30 days).

(3) The MER will calibrate any medical ionizing radiation producing equipment that undergoes a repair service and requires an exchange of parts or certified components that could affect the overall calibration integrity.

e. Thoroughly evaluate and test defibrillators at least semiannually using a defibrillator analyzer. Record the results of the evaluation on DA Form 5624-R (*DC Defibrillator Inspection Record*). A DA Label 175 (*Defibrillator Energy Output Certification*) will be affixed as close as possible to the control panel. A DD Form 2163 is not required for defibrillators.

f. Perform scheduled CVC services in MTOE units at least annually. Portions of CVC requirements affected by replacement of components or repairs to assemblies will be performed upon completion of the service(s). The MER will perform CVC services IAW the applicable MAC. If the MAC does not specify, then perform CVC services at the first authorized level that has the capabilities and test, measurement, and diagnostic equipment (TMDE).

6-13. Repair And Overhaul Costs

a. Elements of cost to be identified to job orders and for use in estimating the cost of repair are—

(1) Direct labor (military and civilian). Labor rates will be computed locally per MACOM/MEDCOM guidance.

(2) Direct materials.

(3) Indirect or overhead costs.

(4) Contractual services.

(5) Shipping and transportation costs (OCONUS activities).

(6) Travel and per diem expenses (including regular labor hours in travel) incurred and attributable solely to unscheduled maintenance (that is, repair). When multiple items are serviced during a trip, the costs will be prorated based on the related direct labor.

b. The MER will determine the maximum one-time repair limitation (MEL) and the estimated repair or overhaul cost per AR 750-1 and TB MED 7. Estimates which exceed the MEL require a waiver from the HCA commander or his designated representative.

c. When equipment is reported to the SICC and USAMMA National Maintenance Point (NMP) for disposition instructions based on cost estimates, the NMP will compare the labor rate used by MTOE MERs with the labor rate of the designated support maintenance activity. The cost estimate should be adjusted to reflect the labor rate of the support maintenance activity before making a decision concerning the disposition of the unserviceable asset.

d. The HCA commander may—

(1) Authorize a repair that exceeds the published maximum expenditure limits for medical materiel (TB MED 7) if—

(a) An urgent need exists to save lives or to prevent suffering and distress.

(b) A replacement item will not be available in time to satisfy the clinical requirement.

(2) Delegate in writing to the DOL/Chief, Logistics the authority to approve waivers of expenditure limits for equipment items where the unit price falls below the MEDCASE threshold.

e. Army Medical Commands and Command Surgeons may grant a permanent waiver to a MEL provided that replacement materiel is approved and submitted for acquisition.

6-14. Test, Measurement, And Diagnostic Equipment (TMDE)

a. The TMDE measures, generates, gauges, tests, inspects, diagnoses, or otherwise examines equipment. It identifies or isolates actual or potential malfunctions or determines compliance with specifications established in technical documents. Medical special purpose TMDE (TMDE-SP) is medical materiel used specifically for the test, calibration, and repair of medical equipment. This TMDE does not include items used to diagnose or treat patients.

b. The AMEDD focal point for TMDE policy is the USAMMA. As the AMEDD TMDE Manager, USAMMA will manage, direct, and control the AMEDD's TMDE program.

(1) The USAMMA will provide life-cycle management for all type classified medical TMDE-SP in support of TOE organizations. The TMDE life-cycle management includes the acquisition approval, repair and calibration support responsibility, and the modernization of TMDE requirements.

(2) All TMDE used in support of medical equipment will be calibrated in accordance with the calibration intervals as specified in TB 43-180.

(3) The TMDE used in support of minimum essential equipment for training (MEET) will be calibrated in accordance with the calibration intervals as specified in TB 43-180.

(4) The TMDE required by AMEDD Army schools curriculum to provide individual training will not require cyclic calibration unless training efficiency or safety is adversely affected. It is MEDCOM policy that all TMDE-GP used in AMEDD school training courses will be calibrated.

c. The HCAs will requisition TMDE only after the following conditions are met—

(1) The TMDE is listed on an authorization document (that is, an MTOE, TDA, CTA, or DA approved exemption).

(2) The OMA or OPA funding has been approved.

(3) Acquisition authority has been received from USAMMA and the U.S. Army Aviation and Missile Command. Items of equipment that are exempted from TMDE acquisition approval are defined in AR 750-43, chap 3.

d. General purpose TMDE (TMDE-GP) support will be accomplished as follows:

(1) All TMDE-GP owners or users will perform operator level maintenance.

(2) The TMDE-GP repair and calibration support will be provided by the area calibration repair center responsible for supporting the geographic area where the TMDE-GP owner or user is located. Calibration intervals are identified in TB 43-180.

(3) The USAMMCE is the designated alternate source to provide repair and calibration support services for type classified medical TMDE-SP within the European Command (EUCOM).

(4) All TMDE calibration procedures will be traceable to the National Institute of Standards and Technology (NIST), or to a natural standard such as the content of oxygen in air at normal pressure and altitude.

(5) All commercial contracts for calibration and repair support will specify, as a minimum, adherence to ANSI Z540.1-94.

(6) The AMEDD activities providing TMDE-SP C&RS will establish and maintain an Instrument Master Record File (IMRF).

(7) Department of the Army Label 80 (U.S. Army Calibrated Instrument) will be used to document TMDE CVC services. The TMDE that is limited in capability will not be partially calibrated.

e. The non-type classified medical TMDE-SP support will be accomplished as follows:

(1) All TMDE-SP owners or users will perform operator level maintenance.

(2) The TMDE-SP repair and calibration support will be obtained per TB 43-180 or by contract maintenance support.

(3) The TMDE-SP calibration intervals are specified in TB 43-180 or manufacturer instructions.

6-20. Repair Parts Procedures

a. Repair parts for medical equipment encompass those components, supplies, and other materials necessary to facilitate unit and higher-level maintenance support of medical equipment. These parts, though normally Class VIII or Class IX items, can include all supply classes where such parts or materials are applicable to the above-described services.

b. The AR 710-2, DA PAMs 710-2-1 and 710-2-2, and TB MED 750-1 contain repair parts stockage and supply policies and procedures.

(1) The AMEDDPAS will used by TDA medical operations to manage repair parts, until DMLSS CAIM or TCAM is fielded.

(2) The TAMMIS MEDMAINT, TCAM, SAMS1, or ULLS-G, if available, will be used by MTOE medical maintenance operations to manage repair parts.

c. The TDA HCA can stock mission essential and minimum order repair parts.

d. The HCA Commander or designee will approve the mission essential parts list annually.

e. Mission essential repair parts must—

(1) Ensure the functioning of lifesaving equipment.

(2) Support equipment for which the manufacturer will no longer supply parts.

(3) Support new equipment until demand data can be established.

APPENDIX F. DRAFT AR 40-61
CHAPTER 7. Environmental Services

I. SIGNIFICANT CHANGES

- The Army Civilian Training, Education, and Development System (ACTEDS) plan for the GS-673, Healthcare Environmental Services Specialist Occupational Series, provides the careerist and the manager with a guide to assist in career enhancement and progression. Training and development planning is essential in developing and enhancing the Chief of Environmental Service's knowledge, skills, and abilities. The ACTEDS, if followed, will provide all EVS personnel the avenue to become more proficient in the field.

- The HCA commander will ensure that the EVSO is a qualified Healthcare Environmental Services Specialist (General Schedule (GS)-673 series). This will ensure that the housekeeping officer is properly qualified for the position as a result of education and/or certification, training and experience.

- The radiation safety officer will control the disposition of radioactive RMW.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 7 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

7-1. Operations

Medical logistics environmental services include: medical textile care, medical housekeeping, and disposition of regulated medical waste (RMW) and radioactive waste.

7-2. Management

The responsibilities of the Environmental Services Officer (EVSO) include: oversight and visibility of medical textile care services (see AR 40-61 Glossary); medical housekeeping services; regulated medical waste (RMW) and radioactive waste disposition.

7-3. Medical Textile Care Services Management

a. The EVSO is functionally responsible for the day-to-day management of textile care services.

b. The LMC may be integrated with another HCA (parent) committee (for example, Environment of Care Committee) if approved by the commander. However, the LMC responsibilities will be fully performed by the parent committee.

c. The RMC EVSO will—

(1) Implement uniform MTF reporting requirements to assess cost effectiveness and quality of laundry and linen distribution services.

(2) Provide regional statistical utilization management data as required by MEDCOM.

7-4. Medical Textile Care Services Operations

The Medical textile care services operation was previously referred to as the Linen Management Program

7-6. Textile Stockage Levels

a. The HCA EVSO will establish a par level for each item of linen stocked.
b. Each using activity will compute user stockage level for all clean linen used.

7-8. Textile Marking

The HCA-owned textiles will be distinctly marked with the name of the HCA.

7-10. Contract Laundry And/Or Textile Distribution Services

a. The EVSO is to be designated as the COR (see AR 5-20) at those medical treatment facilities that directly contract for laundry and/or textile distribution services.
b. The EVSO/COR will--
(1) Ensure the recommended practices provided in American National Standard Institute / Association for the advancement of medical instrumentation (ANSI/AAMI) standard ST65:2000, "Processing of reusable surgical textiles for use in health care facilities," are included in the contract specifications.
(2) Implement a quality assurance surveillance program, independent of the contractor's QC program, to evaluate quality, quantity and timeliness of performance per the contract specifications.

7-11. Medical Housekeeping Services Management

a. The HCA EVSO is responsible for day-to-day management of medical housekeeping services.
b. The RMC EVSO will implement MEDCOM management policy in conjunction with the Regional Tri-Service Medical Logistics Support Program for Logistics Services.

7-14. Regulated Medical Waste

The EVSO/COR will be provided initial and recurrent training in the proper waste collection and handling procedures as specified in AR 40-5, *Preventive Medicine*.

APPENDIX G. DRAFT AR 40-61
CHAPTER 8. Facility Management in Healthcare Activities

I. SIGNIFICANT CHANGES

This is a new chapter to AR 40-61. This chapter was added to define and specify policy for facility management within AMEDD organizations.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 8 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

8-1. Facility Management Overview

a. This chapter describes the roles and responsibilities of the facility manager in every aspect of the facility life cycle management (FLCM) process.

b. The objective of facility management is to provide a reliable inventory of facilities that meets specific codes and standards, maintains accreditation, and affords the best possible healthcare environment for soldiers, family members, and retired beneficiaries.

c. FLCM is the basis for meeting this objective and is the foundation of the USAMEDCOM facility sustainment strategy. FLCM is a strategy of sustainment, restoration, modernization, and replacement of facilities and systems throughout their useful life. FLCM includes the formal process of planning, programming, designing, constructing, commissioning, sustaining, restoring, modernizing, demolition, and reusing to produce the most favorable return on capital and operating investments.

d. The Facility Manager is responsible for the FLCM program. The Facility Manager is supported by an array of technical and management support teams at the RMC, HFPA, USACE, and the MEDCOM.

8-3. Facility Management Functions

Facility management consists of planning, organizing, staffing, directing, and control of all facilities functions. Functions for this activity include:

a. Planning, organizing, staffing, directing, and controlling all facility related activities. This includes conducting a study of the total facilities maintenance and repair, construction, quality assurance, and oversight requirements to arrive at an operations and maintenance management plan and staffing plan for current and future years. A review of all maintenance and construction activity that is planned for inside and outside the facilities must include an impact assessment on the occupying staff and patients.

b. Serving on key committees and boards including, but not limited to: Safety Committee, Space Management Committee, Security Committee, Master Planning, Minor Construction Review Board, Pre-design and Pre-construction review boards, Installation Review Boards, Energy Council, Resource Management and Budget review Boards, and Medical Equipment Capital Improvement Board.

c. Administrative approval and oversight of projects and programs to validate that the projects are in unison with master planning, facility life cycle management strategies, and coordinated with affected staff.

d. Oversight of financial programs to include budgeting and managing funding obligations.

e. Ensuring that facilities meet all applicable requirements for accreditation.

f. Establishing and maintaining liaison with the U.S. Army Center for Public Works (CPW), the respective Major Subordinate Command, and Headquarters.

g. Personnel administration and training.

8-9. RMC Facility Director Responsibilities

The Regional Facility Directors (FDs) are required to assist in the facility management process and provide information to MEDCOM for planning, programming, budget, and execution. The FD is tasked with providing information to the MTF facility managers. The FD is also a proponent for the region, coordinating and ensuring appropriate funding to operate the facilities at each site.

APPENDIX H. DRAFT AR 40-61
CHAPTER 9. Medical Materiel Readiness

I. SIGNIFICANT CHANGES

- The AR 40-61 will address only broad logistics policy issues. Detailed execution guidance will be published in the DA PAM 40-61. The DA PAM will serve as the "How To" manual for logisticians to follow as they execute Class VIII Logistics.

- The USAMMA will mobilize and deploy EAD medical units. USAMMA will provide the unit deployment package of potency and dated medical materiel for FP 1&2, echelon above division units that deploy from D+1 to D+30. USAMMA will also provide Class VIII expendable and durable shortages that are requisitioned by EAD medical units.

- The USAMMA will function as the "Gate Keeper" for EAD Medical units support requirements during mobilization and deployments. FORSCOM will set the priority of support and communicate that information to the USA MEDCOM and USAMMA. The MEDCOM will relay the priority to the IMSAs. The IMSAs have the primary responsibility to mobilize and deploy division and below units, and fill requirements for MCDM, CTA-8-100, and unit/mission specific requirements generated by the units.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 9 – Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

9-2. Readiness Policies and Responsibilities

f. The USAMMA will:

(1) Plan for mobilization and support to deploying and deployed units.

(2) Manage and execute assigned DA and OTSG materiel readiness programs including centrally managed P&D programs, RCHD, and MMPDANBC.

(3) Lead and coordinate the development of materiel acquisition strategies and centrally managed contracts to support mobilization and contingency operations; serve as the single POC to coordinate the execution of centrally managed contracts supporting mobilization and contingency operations.

(4) Provide personnel augmentation to AMC LSE Medical Logistics Support Team (MLST) to coordinate and execute Class VIII APS issue.

(5) Develop and program resources for materiel requirements required to support mobilization and CINC OPLANS and contingency operations.

(6) Maintain accountability for AMEDD owned PMI assets.

9-5. Medical Policy For Management Of Medical Chemical Defense Materiel (MCDM)

a. The purpose of the MCDM program for Defense Against Nuclear Biological and Chemical Agents (MMPDANBC) is:

(1) Provide for the procurement, stockpile, storage, maintenance, and distribution of a broad spectrum of:

(a) Antibiotics
(b) Drugs
(c) Protectants
(d) Biological vaccines
(e) Toxoids
(f) Antitoxins
(g) Medical Chemical Defense Materiel (CDM)

(h) Other related medical products for the prevention and treatment of diseases and effects of NBC agents.

(2) Enhance medical NBC defense to Army forces during:

(a) War operations.

(b) Other than war operations.

(c) Contingency operations (under HQDA and DCSOPS direction).

b. Medical CDM is managed by HQDA and the OTSG. OTSG will program, budget, fund, and coordinate distribution of strategic stockpile materiel procured for individual service member (SM) issue.

c. Service member initial issue of medical CDM will be--

(1) Centrally funded by OTSG.

(2) Stored at strategic locations throughout the world and managed by the USAMMA. These assets will be maintained as Division Ready Brigade (DRB) sets.

d. Release authority for DRB sets is the DA DSCOPS. The DA DSCOPS will coordinate with the AMEDD Operation Center (AOC) for the release of MCDM. The DA DSCOPS will provide release instruction to the AOC in writing; the AOC will then provide written instruction to the MRMC/USAMMA on MCDM release.

APPENDIX I. DRAFT AR 40-61
CHAPTER 10. Managing Medical Assemblages

I. SIGNIFICANT CHANGES

- Information regarding the management of medical assemblages and equipment is found within one chapter (Chapter 10) in the draft *AR 40-61*. Procedural information delineating specific processes on the above topic is being moved to a *DA PAM 40-61*.

- Unit Assemblage (UA) listings are available on the USAMMA's website at www.armymedicine.army.mil/usamma. Users may research UA listings by UIC, UA Code, NSN, LIN, or nomenclature.

- The types of updates that UAs undergo are clarified. Updates are stratified within the context of the regulation into two categories: maintenance and modernization updates.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 10 – The selected paragraph is shown.)*

10-4. Composition Of Medical Equipment Sets

b. Unit assemblage updates.

(3) Units will continue to use the UA list initially fielded with the unit until authorized for update by the USAMMA. With the exception of maintenance changes, commanders will only apply updates when directed otherwise by the USAMMA as part of a materiel fielding action. When UAs are reviewed and approved by the AMEDDC&S as part of a modernization update, a unique NSN will be assigned to that set. The new and old NSN will be authorized under the LIN for that set. Units are to use the UA as specified based on the NSN listed when fielded, as detailed in the Unit's Property Book.

i. Potency and Dated (P & D) materiel. The USAMMA plans, budgets, acquires, and delivers P & D materiel with a shelf life between 12 and 60 months for **non-divisional** medical units. This responsibility is part of a DA centrally managed program. All other units, to include combat units (i.e., SOF, ACR, SIB, IBCT, and other Divisional Units) must maintain P & D materiel either as on-hand or on-order unless directed otherwise by their MACOM.

j. Unit commanders must plan, budget, and acquire that portion of P & D materiel that has a shelf life between 0 and 12 months.

k. Non-potency and dated materiel are those components having an indefinite shelf life or having a shelf life greater than 60 months. Unit commanders must maintain these components as either on hand or on order.

APPENDIX J. DRAFT AR 40-61
CHAPTER 11. Optical Fabrication

I. SIGNIFICANT CHANGES

Optical Fabrication Services has undergone considerable revisions. Therefore, it has been removed from Chapter 8 Section VII, subsections 8-25 through 8-27 and has been designated to a new Chapter 11, titled *Optical Fabrication* in the draft AR 40-61.

II. SPECIAL EMPHASIS *(Synopsis from Chapter 11. Selected paragraphs are shown. Therefore, paragraph numbering may not be sequential.)*

11-1. Optical Fabrication Authority And Overview

a. Optical fabrication is a consolidated effort within DoD. In response to this consolidation, the Optical Fabrication Enterprise (OFE) was formed. The OFE manages the DoD's optical fabrication assets, and meets optical fabrication requirements of all services. All Defense Health Program (DHP) supported laboratories are under the OFE charter.

b. The Navy Surgeon General is designated as the Executive Agent (EA) of the OFE. The EA in turn designated the Commander of Naval Ophthalmic Support and Training Activity (NOSTRA) to provide day-to-day oversight of the enterprise.

c. The Optical Fabrication Advisory Board (OFAB) is established to manage and maintain DoD optical fabrication. The OFAB acts as the primary advisor to the EA. The OFAB operates with a combined staff consisting of members from the Army, Air Force, Navy and one representative from DoD's Secretariat. The chairman of the OFAB is the U.S. Army Medical Command’s Assistant Chief of Staff for Logistics.

11-2. OFL Production Guidance

The Army OFLs will prioritize daily workload as follows (in descending priority):

a. Standard Frame Program eyewear produced prior to Frame of Choice (FOC) or Reimbursable Frame Programs.

b. FOC eyewear produced before that of Reimbursable Frame Program.

c. Reimbursable Frame Program.

11-3. Optical Fabrication Contingency Contracts

a. The OFE is responsible for optical fabrication contingency contracts. The OFE, in coordination with OFAB and Service’s Optical Program Managers will authorize the use of contingency contracts.

b. These contracts will provide optical fabrication support to the MTDA optical laboratories and units when the optical requirement exceeds the OFE capability and when a need for rapid fulfillment of these requirements exists.

c. Conditions for activating the contingency contracts are:
(1) Unit mobilization
(2) Projected surge
(3) Personnel shortages
(4) Professional filler system training requirements
(5) Non-projected surges
(6) Command directed assessments

11-4. Optical Laboratory And Unit Operating Supplies

a. Laboratory operating supply authorizations are:
(1) The initial supply of consumable items incorporated in optical fabrication assemblages for medical MTOE units. This initial supply consists of those items required under average conditions for a period of 30 days. The authorizations for individual items are listed in SC 6545-8-P01 and SC 6545-8-P03.
(2) The initial allowance of consumable optical items authorized in SC 6545-8-P02 for the optical division of MTOE 8-287H6. The abovementioned set consists of quantities required under average conditions for a period of 90 days.

b. Laboratory operating supply levels are as follows:
(1) The OCONUS, MTOE optical laboratories and units will maintain a 30-day level of operating supplies.
(2) The CONUS, MTDA optical laboratories and units will maintain no more than a 15-day level.

11-4.1. Performance Measures

OFLs performance is measured on its ability to produce prescription eyewear in a timely manner. The manager of each OFL will monitor the activity's performance using the indicators described below together with any additional performance indicators considered relevant by the manager. The key indicators used to measure the OFLs performance are:

a. Eyewear for Deployments/Grounded Pilots fabricated within 24-hours.
b. Basic trainee's eyewear fabricated within 48 hours.
c. Standard Frame Eyewear fabricated within 3 days.
d. FOC Eyewear produced within 5 to 10 days.
e. Reimbursable Eyewear fabricated as stipulated in the agreement.

11-7. Completing Optical Fabrication Enterprise Report

The optical laboratory report has been replaced with an online reporting tool embedded in the Federal Logistics Website (http://www.fedlogspt.com/).

a. The report is located on www.fedlogspt.com is a fully integrated online data-reporting tool. The OFE Optical Fabrication Web-tool consists of four reports with content-sensitive instructions integrated within each metric. The OFE report consists of four different metrics titled: Production, Financial, Staff, and Performance. These on-line reports have been developed to capture data and additional information required by OFE and USAMEDCOM.

b. To access www.fedlogspt.com, personnel must register on the site, then contact USAMEDCOM ACSLOG, Logistics Plans and Readiness Division for access to the OFE optical Fabrication web-tool. Once verification and user-level is determined, the user will then be granted access to the OFE Web-tool. Clicking on the OFE button (top menu) will bring you to

the OFE page. Afterwards, click on the left display menu bar and click on **Programs**. Thereafter, click on the top display areas for the various reports in metrics titled, **Production**, **Financial**, **Staff**, and **Performance**. Once input is made, click **SUBMIT**. The information will be stored on an archived, retrievable database.

c. Army optical laboratories and units, including those organized as an element of MTDA and MTOE units, will:

(1) Submit the consolidated optical fabrication enterprise report monthly located on www.fedlogspt.com.

(2) The submitted report will be reviewed through command channels to the appropriate RMC or Command Surgeons. The report will then be reviewed by USAMEDCOM by the tenth of each month.

(3) If additional information or guidance is required on this report or optical issues contact:

USAMEDCOM
ATTN: MCLO-P
2050 Worth Road, Suite 8
Fort Sam Houston TX 78234-6008

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By Order of the Secretary of the Army:
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